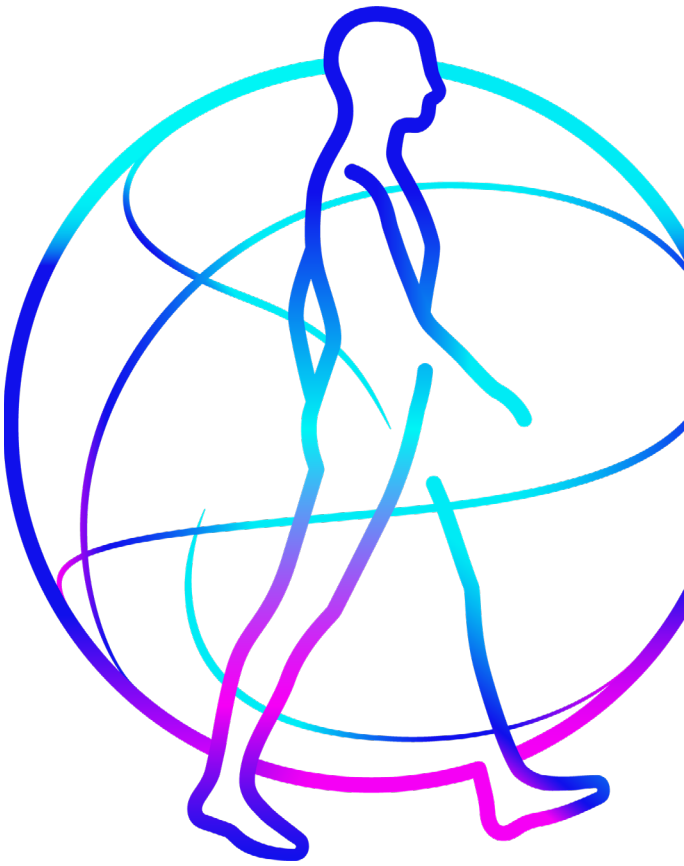
Medtronic



Spinal cord stimulation

2024 Coding and payment guide

What's inside:

For questions please contact Medtronic at rs.neurousreimbursement@medtronic.com

Physician coding and payment

January 1, 2024 – December 31, 2024

Procedure	CPT procedure code and description[a]	Medicare Work RVUs[b]	Medicare national average for physician services provided in:[c]	
			Office	Facility
Screening test[d,1,2]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[3,4,5]	7.15	$2,236	$407
Lead implantation[d,1,2]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[4,5]	7.15	$2,236	$407
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural[6]	10.92	N/A	$838
Generator implantation or replacement[d,7]	**63685** Insertion or replacement of spinal neurostimulator pulse generator or receiver requiring pocket creation and connection between electrode array and pulse generator or receiver	5.19	N/A	$337
Removal of leads[d,8]	**63661** Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed[6]	5.08	$675	$326
	63662 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	11.00	N/A	$851
Revision or replacement of leads[d, 9]	**63663** Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	7.75	$889	$444
	63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	11.52	N/A	$886
Revision or removal of generator[d,7]	**63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	4.35	N/A	$298
Analysis/ programming *Note: In the office, analysis and programming may only be billed by a physician, practitioner with "incident to" status, or auxiliary personnel under supervision of the physician. Programming performed by a manufacturer's representative may NOT be billed.*	**95970** Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, **without programming**[10]	0.35	$18	$18
	95971 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional with **simple** spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter **programming** by physician or other qualified health care professional[11,12,13]	0.78	$47	$38
	95972 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional with **complex** spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter **programming** by physician or other qualified health care professional[11,12,13]	0.80	$56	$39

HCPCS II device codes

Device C-codes

Device	HCPCS II device codes[e, 14]	HCPCS II code description
Pulse generator (non-rechargeable)	C1767	Generator, neurostimulator (implantable), non-rechargeable
Pulse generator (rechargeable)	C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
Pulse generator (rechargeable) Closed Loop	C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system
Extension	C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
Leads	C1778	Lead, neurostimulator (implantable)
	C1897	Lead, neurostimulator, test kit (implantable)
Patient programmer	C1787	Patient programmer, neurostimulator

The device C-codes above are applicable to this therapy. To determine if there is a C-code for a particular Medtronic device, click here for a C-code finder to search by model number, product name, C-code, C-code description, or product category.

Device L-codes

Device	HCPCS II device codes[e]	HCPCS II code description
Lead[15]	L8680	Implantable neurostimulator electrode, each
Pulse generator[16]	L8679	Implantable neurostimulator pulse generator, any type
	L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
External recharger	L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
Patient programmer	L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only

Hospital outpatient coding and payment

Effective January 1, 2024 – December 31, 2024

Procedure	CPT procedure code and description[a]	APC[f]	APC Level	Status Indicator[f,17]	Relative weight[f]	Medicare national average[f,g]
Screening test[1,2]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[3,5]	5462	Level 2	J1	74.6499	$6,523
Lead implantation[1,2]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[5]	5462	Level 2	J1	74.6499	$6,523
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural[6]	5464	Level 4	J1	238.7737	$20,865
Generator implantation or replacement[7]	**63685** Insertion or replacement of spinal neurostimulator pulse generator or receiver requiring pocket creation and connection between electrode array and pulse generator	5465	Level 5	J1	338.9379	$29,617
Removal of leads[8]	**63661** Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed[6,18]	5431	Level 1	Q2	21.0746	$1,842
	63662 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	5461	Level 1	J1	37.1389	$3,245
Revision or replacement of leads[9]	**63663** Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	5462	Level 2	J1	74.6499	$6,523
	63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	5463	Level 3	J1	148.6858	$12,992
Revision or removal of generator[7]	**63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	5461	Level 1	J1	37.1389	$3,245
Revision/ replacement of leads (percutaneous) *plus* **revision of generator**[19]	**63663** Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed *plus* **63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	5463	Level 3	J1	148.6850	$12,992
Revision/ replacement of leads (via laminectomy) *plus* **revision of generator**[19]	**63664** Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed *plus* **63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	5464	Level 4	J1	238.7737	$20,865

Hospital outpatient coding and payment (continued)

Procedure	CPT procedure code and description[a]	APC[f]	APC Level	Status Indicator[f,17]	Relative weight[f]	Medicare national average[f,g]
Analysis/ programming *Note: In the office, analysis and programming may only be billed by a physician, practitioner with "incident to" status, or auxiliary personnel under supervision of the physician. Programming performed by a manufacturer's representative may NOT be billed.*	**95970** Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, **without programming**[10,18]	5734	Level 4	Q1	1.3943	$121.84
	95971 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with **simple** spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter **programming** by physician or other qualified health care professional[11,12,13]	5742	Level 2	S	1.0566	$92.33
	95972 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with **complex** spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter **programming** by physician or other qualified health care professional[11,12,13]	5742	Level 2	S	1.0566	$92.33

ASC coding and payment

January 1, 2024 – December 31, 2024

Procedure	CPT procedure code and description[a]	Payment indicator[h,20,i]	Multiple procedure discounting[21]	Relative weight[h,i]	Medicare national average[h,i]
Screening test[1]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[3,5]	J8	N	92.5354	$4,952
Lead implantation[1]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[5]	J8	N	92.5354	$4,952
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural[6]	J8	N	336.2382	$17,993
Generator implantation or replacement[7]	**63685** Insertion or replacement of spinal neurostimulator pulse generator or receiver requiring pocket creation and connection between electrode array and pulse generator or receiver	J8	N	472.7341	$25,298
Removal of leads[8]	**63661** Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed[6]	G2	N	16.7768	$898
	63662 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	G2	Y	35.4712	$1,898
Revision or replacement of leads[9]	**63663** Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	J8	N	90.8964	$4,864
	63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	J8	N	192.7983	$10,317
Revision or removal of generator[7]	**63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	A2	Y	35.4712	$1,898

Hospital inpatient coding and payment

Effective October 1, 2023 – September 30, 2024

Procedure	ICD-10-PCS procedure codes[j]	ICD-10-PCS procedure code description
Lead implantation[22]	00HU0MZ	Insertion of neurostimulator lead into spinal canal, open approach
	00HU3MZ	Insertion of neurostimulator lead into spinal canal, percutaneous approach
Lead removal[23]	00PU0MZ	Removal of neurostimulator lead from spinal canal, open approach
	00PU3MZ	Removal of neurostimulator lead from spinal canal, percutaneous approach
Lead replacement	Two codes are required to identify a device replacement: one code for implantation of the new device and one code for removal of the old device.[24]	
Lead revision[25]	00WU0MZ	Revision of neurostimulator lead in spinal canal, open approach
	00WU3MZ	Revision of neurostimulator lead in spinal canal, percutaneous approach
Generator implantation[26,27]	0JH70DZ	Insertion of multiple array stimulator generator into back subcutaneous tissue and fascia, open approach
	0JH80DZ	Insertion of multiple array stimulator generator into abdomen subcutaneous tissue and fascia, open approach
	0JH70EZ	Insertion of multiple array rechargeable stimulator generator into back subcutaneous tissue and fascia, open approach
	0JH80EZ	Insertion of multiple array rechargeable stimulator generator into abdomen subcutaneous tissue and fascia, open approach
Generator removal[27]	0JPT0MZ	Removal of stimulator generator from trunk subcutaneous tissue and fascia, open approach
	0JPT3MZ	Removal of stimulator generator from trunk subcutaneous tissue and fascia, percutaneous approach[24]
Generator replacement	Two codes are required to identify a device replacement: one code for implantation of the new device and one code for removal of the old device.	
Generator revision[28,29]	0JWT0MZ	Revision of stimulator generator in trunk subcutaneous tissue and fascia, open approach
	0JWT3MZ	Revision of stimulator generator in trunk subcutaneous tissue and fascia, percutaneous approach

MS-DRG assignments

Note: For certain procedures, DRG assignment varies depending on the primary diagnosis.

- Nervous system disorders include: chronic pain disorders, reflex sympathetic dystrophy (CRPS I), causalgia (CRPS II), arachnoiditis, peripheral neuropathy, epidural fibrosis, and diabetic peripheral neuropathy, as well as device complications and attention to device.
- Musculoskeletal system disorders include: radiculopathy[31], herniated disc/DDD with radiculopathy or sciatica, and post laminectomy syndrome.

Procedure		MS-DRG[k]	MS-DRG title[30]	Relative weight[k]	Medicare national Average[l]
Screening Test	DRGs are not shown for the screening test because this is rarely performed on an inpatient basis. However, if performed, see the "DRGs for implantation" or "Replacement: leads only" section.				
Implantation or replacement: whole system (generator plus leads)	Nervous system disorders[32]	028	Spinal procedures W MCC	6.0261	$42,192
		029	Spinal procedures W CC or spinal neurostimulators	3.4282	$24,003
	Musculoskeletal system disorders[33]	518	Back and neck procedures except spinal fusion W MCC or disc device or neurostimulator	3.6518	$25,568

Hospital inpatient coding and payment - MS-DRG assignments (continued)

Procedure		MS-DRG[1]	MS-DRG title[2]	Relative weight[1]	Medicare national average[3]
Implantation or replacement: generator only (any type)	Nervous system disorders[34]	040	Peripheral/cranial nerve and other nervous system procedures W MCC	3.8505	$26,960
		041	Peripheral/cranial nerve and other nervous system procedures W CC or peripheral neurostimulator	2.2618	$15,618
		042	Peripheral/cranial nerve and other nervous system procedures W/O CC/ MCC	1.7398	$12,181
	Musculoskeletal system disorders[35]	981	Extensive OR procedures unrelated to principal diagnosis W MCC	4.7404	$33,190
		982	Extensive OR procedures unrelated to principal diagnosis W CC	2.4860	$17,406
		983	Extensive OR procedures unrelated to principal diagnosis W/O CC/MCC	1.6352	$11,449
Implantation or replacement: leads only (one or more)	Nervous system Disorders[32]	028	Spinal procedures W MCC	6.0261	$42,192
		029	Spinal procedures W CC or spinal neurostimulators	3.4282	$24,003
		030	Spinal procedures W/O CC/MCC	2.3190	$16,237
	Musculoskeletal system disorders[33]	518	Back and neck procedures except spinal fusion W MCC or disc device or neurostimulator	3.6518	$25,568
		519	Back and neck procedures except spinal fusion W CC	1.9686	$13,783
		520	Back and neck procedures except spinal fusion W/O CC/ MCC	1.4315	$10,023
Removal (without replacement) whole system (generator [any type] plus leads [one or more])[36,37,38]	Nervous system Disorders[32]	028	Spinal procedures W MCC	6.0261	$42,192
		029	Spinal procedures W CC or spinal neurostimulators	3.4282	$24,003
		030	Spinal procedures W/O CC/MCC	2.3190	$16,237
Removal (without replacement) Generator only (any type)[36,37]		These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (ie, medical) DRG is assigned to the stay according to the principal diagnosis.			
Removal (without replacement) Leads only (one or more)[36,37]	Nervous system Disorders[32]	028	Spinal procedures W MCC	6.0261	$42,192
		029	Spinal procedures W CC or Spinal Neurostimulators	3.4282	$24,003
		030	Spinal procedures W/O CC/MCC	2.3190	$16,237
Revision leads only (one or more)[36,37,39]	Nervous system Disorders[32]	028	Spinal procedures W MCC	6.0261	$42,192
		029	Spinal procedures W CC or spinal neurostimulators	3.4282	$24,003
		030	Spinal procedures W/O CC/MCC	2.3190	$16,237
Revision generator only (any type)[36,37]		These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (ie, medical) DRG is assigned to the stay according to the principal diagnosis.			

Annual references

a. CPT codes, descriptions and other data only are copyright 2023 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply. Fee schedules, relative value units, conversion factors and/or related components aren't assigned by the AMA, aren't part of CPT, and the AMA isn't recommending their use. The AMA doesn't directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

b. Centers for Medicare & Medicaid Services. CY 2024 MPFS Final Rule Home Page. Although the total RVU consists of three components, only the physician work RVU is shown.

c. Medicare national average payment is determined by multiplying the total RVU for a CPT code by the conversion factor, which is $32.7375 for CY 2024. CY 2024 MPFS Final Rule Home Page

d. Surgical procedures are subject to a "global period." The global period defines other physician services that are generally considered part of the surgery and are not separately coded, billed, or paid when rendered by the physician who performed the surgery. The services include preoperative visits the day before or the day of the surgery; postoperative visits related to recovery from the surgery for 10 or 90 days, depending on the specific procedure; treatment of complications, unless they require a return visit to the operating room; and minor postoperative services such as dressing changes and suture removal. Medicare claims processing manual, chapter 12.

e. HCPCS quarterly update These codes are used by the entity that purchased and supplied the medical device. For Medicare hospital outpatient claims, C-Codes are required. For Medicare ASC claims C-Codes are not reported for packaged items, yet may be reported for non-packaged items such as items with transitional pass-through status. C1826 has Medicare pass transitional pass-through status effective 1/1/23-12/31/25. For non-Medicare hospital or ASC claims, please consult payer specific contracts for whether C or L codes would be billed.

f. Centers for Medicare & Medicaid Services. CY 2024 OPPS Final Rule Home Page.

g. Medicare national average payment is determined by multiplying the APC weight by the conversion factor of $87.382 for CY 2024, which assumes that hospitals meet reporting requirements of the Hospital Outpatient Quality Reporting Program: CY 2024 OPPS Final Rule Home Page.

h. Centers for Medicare & Medicaid Services. CY 2024 ASC Final Rule Home Page.

i. Medicare national average payment is determined by multiplying the ASC weight by the conversion factor of $53.514 for CY 2024, which assumes the ASC meets reporting requirements. CY 2024 ASC Final Rule Home Page.

j. https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-pcs

k. Centers for Medicare & Medicaid Services. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page FY 2024 IPPS Final Rule Home Page

l. Payment is based on the average standardized operating amount ($6,497.77) plus the capital standard amount ($503.83). The payment rate shown is the standardized amount for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. FY 2024 IPPS Final Rule Home Page

Coding footnotes

1. As defined and as published by the AMA (CPT Assistant, June 1998, p.4), code 63650 and code 63655 each represent a single lead. When more than one lead is placed, each lead is coded separately. However, Medicare does not permit the use of bilateral modifier –50 or –LT/ –RT on these codes. Some payers recognize that each code represents a distinct lead when modifier –51 or modifier –59 is appended to the additional codes. Note that Medicare's Medically Unlikely Edits (MUE) allow 2 units for code 63650 on the same date of service, but only 1 unit for code 63655. Denials for units in excess of the MUE values may be appealed. For billing multiple leads to non-Medicare payers, contact the payer forinstructions.

2. The published vignettes for codes 63650 and 63655 include fluoroscopy and, according to guidelines published by the American Association of Neurological Surgeons (AANS Managing Coding & Reimbursement Challenges in Neurosurgery, 2020 Workbook, p.361-362), its use is inherent to lead implantation and should not be coded separately. In addition, National Correct Coding Initiative (NCCI) edits prohibit coding fluoroscopy separately with 63650 and 63655. See also CPT Assistant, January 2016, p.12.

3. The AMA has published that the work of removing a temporary trial lead is inherent to the original percutaneous placement code 63650 and is not coded separately. This applies even outside of the global period. When a temporary trial lead is not removed but is left in place and converted to a permanent lead by connection to an implanted generator, the work is included in the generator code and no additional code is used for lead removal or revision. See CPT Assistant, April 2011, p.10 (Q2)(Q4)

4. The Physician Office RVUs for code 63650 are valued to include payment for the lead and other practice expenses associated with office-based lead insertion, eg, screening tests (trials). HCPCS code L8680 should not be reported separately for the lead in conjunction with office-based lead insertion.

5. The AMA has published (CPT Assistant, October 2013, p.19) that use of an incision to admit the needle or to anchor the lead is inherent to percutaneous placement and does not alter use of code 63650. See also 2019 AANS Guide to Coding, p.68.

6. The AMA has published that when a permanent percutaneous lead is removed and a new lead is placed via a fresh laminectomy at the same or a different spinal level, insertion code 63655 is assigned with removal code 63661. CPT Assistant, April 2011, p.11,15. NCCI edits allow this combination without use of a modifier.

7. When an existing generator is removed and replaced by a new generator, only the generator replacement code 63685 may be assigned. NCCI edits do not allow removal of the existing generator to be coded separately. Also note that, according to NCCI policy, use of CPT code 63685 for generator "insertion or replacement" requires placement of a new generator. When the same generator is removed and then re-inserted, the "revision" code 63688 is used. NCCI Policy Manual 1/1/2023, Chapter VIII, C.16.

8. Codes 63661 and 63662 apply to surgical removal of permanent leads. Code 63661 cannot be assigned for removal of a temporary trial lead that was placed percutaneously. Removal of a permanent lead by simple pull is not coded. CPT Assistant, August 2010, p.8,15; April 2011, p.10-11,15. See also AANS Managing Coding & Reimbursement Challenges in Neurosurgery, 2020 Workbook, p.361.

9. The AMA has published that replacement codes 63663 and 63664 are assigned when a permanent lead is replaced by another permanent lead of the same type via the same approach at the same spinal level. The work of removing the existing permanent lead is included and is not coded separately. CPT Assistant, August 2010, p.8,15; April 2011, p.10-11,15. In addition, NCCI edits do not permit removal codes 63661 and 63662 to be assigned separately with replacement codes 63663 and 63664.

10. Code 95970 is used for electronic analysis (interrogation) of the implanted neurostimulator without programming. Per CPT manual instructions, code 95970 is integral to lead and/or generator implantation and cannot be assigned separately. See also CPT Assistant, February 2019, p.6. NCCI edits also prohibit coding 95970 separately with lead or generator implantation. In addition, per CPT manual instructions, test stimulation during an implantation procedure is considered integral and code 95970 cannot be assigned to represent this.

11. Per CPT manual instructions, programming codes 95971 and 95972 may not be assigned to represent test stimulation during the implantation procedure. However, the instructions clarify that actual programming performed at the time of lead or generator implantation is not integral and may be coded separately. NCCI edits prohibit use of programming codes 95971 and 95972 with lead or generator implantation codes, but they allow an override in this scenario.

12. According to CPT manual instructions, "simple" programming involves changes to three or fewer parameters and "complex" programming involves changes to four or more parameters.

13. According to CPT manual instructions, programming codes may be assigned as long as iterative adjustments to the parameters are made and assessed, regardless of whether the final settings are ultimately changed. See also CPT Assistant, February 2019, p.6.

14. ASCs should report all charges incurred. However, only charges for non-packaged items, eg, device codes eligible for pass-through payment, should be billed as separate line items. For example, the ASC should report its charge for the lead but because the lead is a packaged item, the charge should not be reported on its own line. Instead, the ASC should bill a single line for the implantation procedure with a single total charge, including not only the charge associated with the operating room but also the charges for the lead device and all other packaged items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14–Ambulatory Surgical Centers, Section 40. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Accessed November 30, 2022.

15. Physicians should not submit code L8680 to Medicare for leads placed in the office, because the cost of the lead is already valued in the practice expense for the CPT procedure code. Code L8680 is also not recognized as valid by Medicare. Code L8680 remains available for use with non-Medicare payers, though providers should check with the payer for specific coding and billing instructions.

16. Generator codes L8686-L8688 are not recognized as valid by Medicare. Specifically for billing Medicare, hospitals typically use C-codes and ASCs generally do not submit HCPCS II codes for devices. For non-Medicare payers, codes L8686-L8688 remain available. However, all providers should check with the payer for specific coding and billing instructions.

17. Status Indicator (SI) shows how a code is handled for payment purposes: J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; S = always paid at 100% of rate; Q1 = STV packaged codes, not paid separately when billed with an S, T, or V procedure; Q2 = T packaged codes, not paid separately when billed with a T procedure. See note 14 for more detailed information on the Status Indicators for codes 63661 and 95970.

18. For Status Indicators, code 63661 is Q2 and code 95970 is Q1, indicating that these codes are generally not paid separately when billed with other procedure codes. When billed alone, code 63661 is J1 and code 95970 is S.

19. The combination of code 63663 and 63688 qualifies for a complexity adjustment. Individually, code 63663 maps to APC 5462 and code 63688 maps to APC 5461, but when submitted together, the entire encounter is re-mapped to APC 5463. Similarly, the combination of code 63664 and 63688 qualifies for a complexity adjustment. Individually, code 63664 maps to APC 5463 and code 63688 maps to APC 5461, but when submitted together, the entire encounter is re-mapped to APC 5464.

20. The Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost; A2 = surgical procedure, payment based on hospital outpatient rate adjusted for ASC; G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC.

21. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedure and 50% of the rate for the second and all subsequent procedures. These procedures are marked "Y." However, procedures marked "N" are not subject to this discounting and are paid at 100% of the rate regardless of whether they are submitted with other procedures.

22. Approach value 0-Open is used when leads are placed via laminectomy. Approach value 3-Percutaneous is used when leads are placed by spinal needle via puncture or minor incision.
23. Approach value 0-Open is used when leads are removed via laminectomy or other direct surgical exposure of the spinal canal. Approach value 3-Percutaneous is used when leads are removed by puncture or minor incision. Only the ICD-10-PCS codes for surgical removal are displayed. Approach value X-External is also available for removal of leads by simple pull.
24. CMS ICD-10-PCS Reference Manual 2016, p.67. See also Coding Clinic,3rd Q 2014, p.19-20.
25. For lead revision, the ICD-10-PCS codes refer to surgical revision of leads within the spinal canal, eg, repositioning. For revision of the subcutaneous portion of the lead or revision of a subcutaneous extension, see Generator Revision.
26. Codes defined as "multiple array" include dual array neurostimulator pulse generators, a type of multiple array generator in which two leads are connected to one generator. See the ICD-10-PCS Device Key for specific model names and related device values. Do not assign default device value M-Stimulator Generator.
27. Placement of a neurostimulator generator is shown with the approach value 0-Open because creating the pocket requires surgical dissection and exposure. Removal also usually requires surgical dissection to free the device.
28. The ICD-10-PCS codes shown can be assigned for opening the pocket for generator revision, as well as reshaping or relocating the pocket while reinserting the same generator. However, there are no ICD-10-PCS codes specifically defined for revising the subcutaneous portion of a lead or an extension. Because these services usually involve removing and reinserting the generator as well, they can also be represented by the ICD-10-PCS generator revision codes.
29. Approach value X-External is also available for external generator manipulation without opening the pocket, eg. to correct a flipped generator.
30. W MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs W MCC have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs W CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs W/O CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.
31. Radiculopathy is considered a musculoskeletal disorder for DRG purposes, with two exceptions: cervical and cervicothoracic codes M54.12 and M54.13 are considered nervous system disorders.
32. There are three MS-DRGs for spinal procedures with a nervous system principal diagnosis: DRGs 028, 029, and 030. The difference is whether secondary diagnoses are designated as MCCs or CCs. However, for a whole system neurostimulator implantation in which both generator plus leads are coded, MS-DRG 030 cannot be assigned. Instead, MS-DRG 029 is automatically assigned for a whole system implantation regardless of whether a CC is present or not. If an MCC is also present with a whole system implantation, MS-DRG 028 is assigned. For other spinal procedures, such as lead only implantation or lead removal, the full range of MS-DRGs 028, 029, and 030 is available.
33. There are three MS-DRGs for back and neck procedures with a musculoskeletal system principal diagnosis: DRGs 518, 519 and 520. The difference is whether secondary diagnoses are designated as MCCs or CCs. However, for a whole system neurostimulator implantation in which both generator plus leads are coded, MS-DRG 518 is automatically assigned regardless of whether an MCC is present. For other spinal procedures, such as lead only implantation, the full range of MS-DRGs 518, 519 and 520 is available.
34. The ICD-10-PCS codes for generator implantation are not specific to spinal neurostimulation so the MS-DRGs for Other Nervous System Procedures are assigned rather than the MS-DRGs for Spinal Procedures.
35. The generator implantation codes are designated as nervous system procedures only. When a musculoskeletal disorder is used as the principle diagnosis, the "mismatch" DRGs of 981, 982, and 983 are assigned. These DRGs are valid and payable.
36. Procedures involving device removal without replacement and device revision are typically performed as an outpatient. They are shown here for the occasional scenario where removal or revision take place as an inpatient.
37. Neurostimulators may be revised or removed for diagnoses involving device complications or attention to device, which are classified as nervous system disorders. Because neurostimulators are classified as nervous system devices, removal and revision procedures are assigned to Nervous System MS-DRGs in these scenarios.
38. When the generator and leads are removed together, the lead removal code is the "driver" and groups to the DRGs shown.
39. For lead revision, the DRGs reflect surgical revision of the intraspinal portion of the lead, eg, repositioning a displaced lead within the spinal canal.